

Fact Sheet

North Carolina's Transition of 1915(b)(3) Benefits to 1915(i)

Frequently Asked Questions (FAQs)

Home and community-based services (HCBS) provide opportunities for community integration, enabling Medicaid enrollees to obtain services in their community. North Carolina's local management entities/managed care organizations (LME/MCOs) provide 1915(b)(3) services, which offer a critical set of HCBS to Medicaid enrollees with significant behavioral health needs and intellectual/developmental disabilities (I/DD).

Because Behavioral Health I/DD Tailored Plans will be operating under North Carolina's 1115 demonstration, they will no longer be able to provide services under the 1915(b)(3) authority. To ensure that individuals maintain access to these critical services when Tailored Plans launch, North Carolina is transitioning 1915(b)(3) services to 1915(i) services.

With this transition, North Carolina is expanding the populations eligible for some of these important services. Trainings provided by DHHS on the 1915(b)(3) to 1915(i) transition, can be accessed at the below links:

- [TCM Provider Slides](#)
- [Service Provider Slides](#)

Federal rules require that to obtain 1915(i) benefits, an individual must obtain an independent assessment to be used to develop a service plan, called a Care Plan (for individuals with behavioral health needs) or Individual Support Plan (ISP) (for individuals with an I/DD or traumatic brain injury TBI) in North Carolina. This FAQ provides answers to common questions about North Carolina's transition from 1915(b)(3) to 1915(i) services.

Timeline for 1915(b)(3) to 1915(i)

WHEN WILL THE 1915(B)(3) TO 1915(I) TRANSITION OCCUR? WHAT IS REQUIRED FOR INDIVIDUALS CURRENTLY OBTAINING 1915(B)(3) SERVICES TO MAINTAIN THESE SERVICES WITH THE 1915(I) TRANSITION?

Pending federal approval, DHHS anticipates that 1915(i) services be available starting on July 1, 2023. The Department is committed to ensuring that individuals currently obtaining 1915(b)(3) services do not experience disruption in their covered services during the transition to 1915(i) authority. At the same time, the Department recognizes that it is a significant lift LME/MCOs, advanced medical home plus (AMH+) practices, and care management agencies (CMAs) to conduct 1915(i) assessments and develop and/or update Care Plans/ISPs to meet 1915(i) requirements.

As a result, to ensure a smooth transition, the Department is phasing-in individuals' transition from 1915(b)(3) to 1915(i) services and recommends that LME/MCOs initially prioritize individuals who will enroll in a Tailored Plan on Oct.1, 2023. The timing of the transition is:

- **Individuals who have an open 1915(b)(3) service authorization and will enroll in a Tailored Plan will transition to 1915(i) services by Oct.1, 2023.** This means that to transition their 1915(b)(3) service authorization to 1915(i), they must have completed a 1915(i) assessment and have a Care Plan/ISP in place that meets 1915(i) requirements by Oct.1, 2023 (see additional detail below).
- **Individuals who have an open 1915(b)(3) service authorization and will remain enrolled in NC Medicaid Direct when Tailored Plans launch will transition to 1915(i) services by July 1, 2024.** This means that to transition their 1915(b)(3) service authorization to 1915(i), they must have completed a 1915(i) assessment and have a Care Plan/ISP in place that meets 1915(i) requirements by July 1, 2024 (see additional detail below). For the purpose of phase-in, LME/MCOs should target completing the 1915(i) independent assessment in the individual's birthday month.

WILL INDIVIDUALS CURRENTLY OBTAINING 1915(B)(3) SERVICES MAINTAIN ACCESS TO THESE SERVICES WHEN 1915(I) SERVICES LAUNCH?

Yes, individuals currently obtaining 1915(b)(3) services will maintain access to their current services until they have completed a 1915(i) assessment and transition to 1915(i) services according to the phased approach described in the transition timeline (refer to the above question "When will the 1915(b)(3) to 1915(i) transition occur?") The phase-in process is designed to ensure that individuals experience continuity of care, while ensuring that the transition meets federal requirements.



WHEN CAN INDIVIDUALS WHO HAVE NOT PREVIOUSLY OBTAINED 1915(B)(3) SERVICES OBTAIN 1915(I) SERVICES?

Pending federal approval, individuals who have not previously obtained 1915(b)(3) services can obtain 1915(i) services on July 1, 2023, assuming that they have completed a 1915(i) assessment, are evaluated as eligible for the service, and have a Care Plan/ISP in place that meets 1915(i) requirements.

1915(i) Independent Assessment & Care Plan/ISP Requirements

WHY ARE INDIVIDUALS REQUIRED TO OBTAIN A 1915(I) INDEPENDENT ASSESSMENT TO USE 1915(I) SERVICES?

Federal rules require that individuals obtain an independent assessment to use 1915(i) services. Individuals must obtain a 1915(i) independent assessment in order to:

- Confirm they are eligible for 1915(i) services,
- Identify and confirm their needed services and supports
- Provide information necessary for completing their Care Plan/ISP.

WHAT IS THE DIFFERENCE BETWEEN A CARE PLAN AND AN INDIVIDUAL SUPPORT PLAN (ISP)?

A Care Plan and ISP both (a) incorporate the results of the care management comprehensive assessment, and (b) identifies the member/recipient's desired outcomes and the training, therapies, services, strategies, and formal and informal supports needed for the member to achieve those outcomes. The Department is using different names for this plan according to a person's needs:

- For individuals with behavioral health-related needs, a care manager/care coordinator will develop a Care Plan.
- For individuals with I/DD and TBI-related needs, a care manager/care coordinator will develop an ISP.

Both the Care Plan and ISP must be individualized, person-centered, and developed using a collaborative approach including individual and family participation where appropriate. Additional information on Care Plans/ISPs is available in the Tailored Care Management Provider Manual found on the [Tailored Care Management page](#).



WHO IS RESPONSIBLE FOR COMPLETING THE 1915(I) ASSESSMENT AND CARE PLAN/ISP FOR INDIVIDUALS WHO ARE LOOKING TO OBTAIN 1915(I) SERVICES?

The entities responsible for completing the 1915(i) assessment and Care Plan/ISP are described below. 1915(i) independent assessments and Care Plan/ISP development must always be conducted by a care manager/care coordinator and may not be conducted by a care manager extender.

Now Through Oct. 1, 2023:

In the current time period through Oct. 1, 2023, LME/MCOs are responsible for:

- Identifying their members with open 1915(b)(3) service authorizations;
- Conducting outreach to these individuals;
- Completing the 1915(i) assessment for these individuals and submitting the 1915(i) independent assessment to Carelon, the Department's vendor that will collect independent assessments. The Department will subsequently determine eligibility for 1915(i) services; and
- Updating or completing the individual's Care Plan/ISP to account for the individual's needed 1915(i) services and supports.

For individuals obtaining Tailored Care Management, LME/MCOs may also delegate the responsibility for completing the 1915(i) independent assessment and Care Plan/ISP to the individual's assigned AMH+ or CMA.

Post-Oct. 1, 2023

For individuals who have engaged in Tailored Care Management, the organization where an individual obtains Tailored Care Management (i.e., AMH+, CMA, LME/MCO, or Tailored Plan) is responsible for:

- Completing the 1915(i) independent assessment and reassessments for individuals in need of 1915(i) services;
- Transmitting the 1915(i) independent assessment to Carelon, the Department's vendor that will collect independent assessments. The Department will subsequently determine eligibility for 1915(i) services;
- Updating or completing the individual's Care Plan/ISP to account for the individual's needed 1915(i) services and supports;
- Transmitting the 1915(i) independent assessment and Care Plan/ISP to the individual's LME/MCO or Tailored Plan for service authorization.

The Tailored Plan or LME/MCO care coordinator will be responsible for conducting these functions for individuals who have not engaged in Tailored Care Management.

WHAT ARE THE COMPONENTS OF THE 1915(I) ASSESSMENT? WHAT TRAININGS ARE AVAILABLE FOR CARE MANAGERS ON HOW TO COMPLETE THE 1915(I) ASSESSMENT?

The 1915(i) independent assessment uses a standardized template issued by the Department, accessible at this link. AHEC provided trainings for LME/MCO and AMH+/CMA care managers on



how to complete the 1915(i) independent assessment in February 2023. Training materials for the assessment training are [here](#).

HOW OFTEN DOES A 1915(i) INDEPENDENT ASSESSMENT HAVE TO BE COMPLETED?

Following the completion of an initial 1915(i) independent assessment, an individual must obtain a 1915(i) independent assessment at least annually or when their circumstances or needs change significantly. Care managers/care coordinators will use the same 1915(i) independent assessment standardized template issued by the Department when conducting reassessments.

For individuals who are engaged in Tailored Care Management, completion of the annual 1915(i) independent assessment should be incorporated into the individual's annual care management comprehensive assessment to minimize the number of assessments that an individual is required to undergo.

WHAT INFORMATION SPECIFIC TO 1915(i) SERVICES MUST BE INCLUDED IN THE CARE PLAN/ISP? IS THERE A REQUIRED TEMPLATE TO USE?

While there is no required template for a Care Plan or ISP, Tailored Care Management requirements outline the minimum elements that must be included in the content of a Care Plan/ISP (see Section 4.4. Care Plans and Individual Support Plans in the Tailored Care Management Provider Manual).

For individuals obtaining or seeking to obtain 1915(i) services, there are additional requirements for the member's Care Plan/ISP to incorporate results from the individual's 1915(i) independent assessment and the individual's desired type, amount, and duration of 1915(i) services. This additional information is needed because care managers/care coordinators will submit Care Plans/ISPs to an individual's Tailored Plans or LME/MCO to authorize needed 1915(i) services.

This approach is similar to the use of the ISP in service authorization for Innovations waiver enrollees. These additional Care Plans/ISP requirements apply for all individuals obtaining 1915(i) services, regardless of whether they are engaged in Tailored Care Management.

As part of developing the Care Plan/ISP for these members, the member's care manager must:

- Explain options regarding the services available and discuss the duration of each service;
- Include in the Care Plan/ISP a plan for coordinating 1915(i) services;
- Ensure the enrollee provides a signature (wet or electronic) on the Care Plan/ISP to indicate informed consent, in addition to ensuring that the Care Plan/ISP includes signatures from all individuals and providers responsible for its implementation. As part of the consent process, members must consent to the following:
 - By signing this plan, I am indicating agreement with the bulleted statements listed here unless crossed through. I understand that I can cross through any statement with which I disagree.
 - My care manager helped me know what services are available.



- I was informed of a range of providers in my community qualified to provide the service(s) included in my plan and freely chose the provider who will be providing the services/supports.
- The plan includes the services/supports I need.
- I participated in the development of this plan.
- I understand that my care manager will be coordinating my care with the [Tailored Plan or LME/MCO] network providers listed in this plan.

HOW DO THE 1915(I) REQUIREMENT FOR CARE PLANS/ISP RELATE TO THE CARE PLAN/ISP REQUIREMENTS FOR TAILORED CARE MANAGEMENT?

To the extent that an individual is engaged in Tailored Care Management, information from an individual's 1915(i) assessment should be incorporated into the same Care Plan/ISP that is used for Tailored Care Management. The Department believes that individuals who need 1915(i) services will benefit from having a single plan that documents their whole-person needs, including, but not limited to, their need for HCBS.

IS A PERSON-CENTERED PLAN (PCP) REQUIRED FOR AN INDIVIDUALS TO ACCESS 1915(I) SERVICES?

While NC Medicaid has historically required providers to complete a PCP for an individual to obtain authorization for 1915(b)(3) services, the PCP will no longer be used for authorization of 1915(i) services.

As noted above, the Department believes that individuals who need 1915(i) services will benefit from having a single Care Plan or ISP that documents their whole-person needs, including, but not limited to, their need for 1915(i) services. Additionally, because 1915(i) services are HCBS, they are subject to federal conflict-free rules, meaning that one provider organization cannot both deliver 1915(i) services and conduct the 1915(i) independent assessment and Care Plan/ISP development for the same individual. For additional guidance please see the Department's [Guidance on Conflict-Free Care Management for Tailored Plan Members](#).

Accordingly, the Department is requiring that for individuals in need of 1915(i) services, the Care Plan or ISP used for Tailored Care Management should also be used to document an individual's need for 1915(i) services. Individuals who have opted out of Tailored Care Management must still work with a Tailored Plan or LME/MCO care coordinator to develop a Care Plan/ISP to obtain 1915(i) services. As noted above, for all individuals obtaining 1915(i) services, the Care Plan/ISP will be submitted to Tailored Plans or LME/MCOs for 1915(i) service authorization.

North Carolina will continue to require that providers complete a PCP to authorize the delivery of certain behavioral health services as described in the following Clinical Coverage Policies:

- Clinical Coverage Policy 8A. Enhanced Mental Health and Substance Abuse Services
- Clinical Coverage Policy 8A-1. Assertive Community Treatment (ACT) Program
- Clinical Coverage Policy 8A-6. Community Support Team



- Clinical Coverage Policy 8C. Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers
- Clinical Coverage Policy 8D-1. Psychiatric Residential Treatment Facilities for Children under the Age 21
- Clinical Coverage Policy 8D-2. Residential Treatment Services
- Clinical Coverage Policy 8G. Peer Support Services

All policies can be located on the [NC Medicaid Program Specific Clinical Coverage Policies page](#).

CAN INDIVIDUALS HAVE BOTH A PCP AND CARE PLAN/ISP?

All individuals engaged in Tailored Care Management are required to have a Care Plan or ISP. Many individuals engaged in Tailored Care Management will also be using one of the services (e.g., Enhanced Mental Health and Substance Abuse Services) outlined in the question, “Is a Person-Centered Plan (PCP) required for an individual to access 1915(i) services?”. Therefore, the Department expects that many individuals—regardless of whether they are using 1915(i) services— will have both a PCP and a Care Plan/ISP.

To reduce the time required to complete the PCP and Care Plan/ISP and ensure consistency across these documents, an individual's care manager/care coordinator should incorporate information from the individual's PCP into their Care Plan/ISP to the maximum extent possible and vice versa. See the scenario below for an example.



Example Scenarios of Individuals with Both a PCP and Care Plan/ISP

Scenario A. Individual with Serious Mental Illness (SMI) is not Obtaining a 1915(i) Service; Has Both a Care Plan and PCP



Scenario A

- Joe has a SMI and is enrolled in a Tailored Plan.
- He is engaged in Tailored Care Management and has a care manager based at a CMA.
- Joe is currently obtaining the following service:
 - ✓ Community Support Team (not a 1915(i) service)

- Joe has a **PCP** that details his rehabilitative goals and is used for the authorization of the Community Support Team service.
- Joe's **PCP** is developed by his service provider.

- Joe has a **Care Plan** that was developed by his care manager upon Joe's engagement in Tailored Care Management.
- Joe's **Care Plan** incorporates information from his PCP, including his rehabilitative goals.



Alt Text - Scenario A:

Joe has a SMI and is enrolled in a Tailored Plan.

He is engaged in Tailored Care Management and has a care manager based at a CMA.

Joe is currently obtaining the following service: Community Support Team (not a 1915(i) service)

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Joe has a PCP that details his rehabilitative goals and is used for the authorization of the Community Support Team service.

Joe's PCP is developed by his service provider.

Right Side Box:

Joe has a Care Plan that was developed by his care manager upon Joe's engagement in Tailored Care Management.

Joe's Care Plan incorporates information from his PCP, including his rehabilitative goals.

Scenario B. Individual with SMI is Obtaining a 1915(i) Service; Has Both a Care Plan and PCP



Scenario B

- Ana has an SMI and is enrolled in an LME/MCO.
- She is engaged in Tailored Care Management and has a care manager based at a CMA.
- Ana is obtaining the following two services:
 - ✓ Community Transition (a 1915(i) service), and
 - ✓ Peer Support Services (not a 1915(i) service)

- Ana has a **PCP** that details her rehabilitative goals and is used for the authorization of Peer Supports Services.
- Ana's **PCP** is developed by her service provider.

- Ana has a **Care Plan** that was developed by her care manager upon Ana's engagement in Tailored Care Management.
- Ana's **Care Plan** incorporates information from her PCP, including her rehabilitative goals.
- After being determined eligible for 1915(i) services, Ana's care manager updates her **Care Plan** with her desired type, amount, and duration of 1915(i) services.
- Ana's care manager submits her 1915(i) assessment and **Care Plan** to her LME/MCO for service authorization.



Alt Text - Scenario B:

Ana has an SMI and is enrolled in an LME/MCO.

She is engaged in Tailored Care Management and has a care manager based at a CMA.

Ana is obtaining the following two services: Community Transition (a 1915(i) service), and Peer Support Services (not a 1915(i) service)

Left Side Box:

Ana has a PCP that details her rehabilitative goals and is used for the authorization of Peer Supports Services.

Ana's PCP is developed by her service provider.

Right Side Box:

Ana has a Care Plan that was developed by her care manager upon Ana's engagement in Tailored Care Management.

Ana's Care Plan incorporates information from her PCP, including her rehabilitative goals.

After being determined eligible for 1915(i) services, Ana's care manager updates her Care Plan with her desired type, amount, and duration of 1915(i) services.

Ana's care manager submits her 1915(i) assessment and Care Plan to her LME/MCO for service authorization.

Scenario C. Individual with Intellectual and Developmental Disability (I/DD) is Obtaining a 1915(i) Service; Has Only an IS





Scenario C

- Roger has an Intellectual and Developmental Disability (I/DD). He is enrolled in a Tailored Plan.
- Roger is obtaining the following service:
 - ✓ Community Transition (a 1915(i) service)
- Roger has opted out of Tailored Care Management. To help coordinate his 1915(i) service, he instead has a care coordinator based at this Tailored Plan.

- Roger does not have a PCP.

- Roger did not have an existing **Individual Support Plan (ISP)** prior to being determined eligible for a 1915(i) service.
- After being determined eligible for 1915(i) services, Roger's care coordinator develops an **ISP** with his desired type, amount, and duration of 1915(i) services.
- Roger's care coordinator submits his 1915(i) assessment and **ISP** to his Tailored Plan for service authorization.

Alt Text - Scenario C:

Roger has an Intellectual and Developmental Disability (I/DD). He is enrolled in a Tailored Plan.

Roger is obtaining the following service: Community Transition (a 1915(i) service)

Roger has opted out of Tailored Care Management. To help coordinate his 1915(i) service, he instead has a care coordinator based at this Tailored Plan.

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Roger does not have a PCP.

Right Side Box:

Roger did not have an existing Individual Support Plan (ISP) prior to being determined eligible for a 1915(i) service.

After being determined eligible for 1915(i) services, Roger's care coordinator develops an ISP with his desired type, amount, and duration of 1915(i) services.

Roger's care coordinator submits his 1915(i) assessment and ISP to his Tailored Plan for service authorization.



Scenario D. Individual with Severe SUD is Obtaining a 1915(i) Service; Has Both a Care Plan and PCP



Scenario D

- Mia has a Severe SUD and is enrolled in a Tailored Plan.
- Mia is obtaining the following two services:
 - ✓ Supported Employment (a 1915(i) service), and
 - ✓ Peer Support Services (not a 1915(i) service)
- She has opted out of Tailored Care Management. To help coordinate her 1915(i) service, she instead has a care coordinator based at her Tailored Plan.

- Mia has a **PCP** that details her rehabilitative goals and is used for the authorization of Peer Supports Services.
- Mia's **PCP** is developed by her service provider.

- Mia did not have an existing **Care Plan** prior to being determined eligible for a 1915(i) service.
- After being determined eligible for 1915(i) services, Mia's care coordinator develops a **Care Plan**, incorporating information from her PCP.
- Mia's care coordinator includes in her **Care Plan** her desired type, amount, and duration of 1915(i) services.
- Mia's care coordinator submits her 1915(i) assessment and **Care Plan** to her Tailored Plan for service authorization.

Alt Text - Scenario D:

Mia has a Severe SUD and is enrolled in a Tailored Plan.

Mia is obtaining the following two services: Supported Employment (a 1915(i) service), and Peer Support Services (not a 1915(i) service)
She has opted out of Tailored Care Management. To help coordinate her 1915(i) service, she instead has a care coordinator based at her Tailored Plan.

Left Side Box:

Mia has a PCP that details her rehabilitative goals and is used for the authorization of Peer Supports Services.
Mia's PCP is developed by her service provider.

Right Side Box:



Mia did not have an existing Care Plan prior to being determined eligible for a 1915(i) service.

After being determined eligible for 1915(i) services, Mia's care coordinator develops a Care Plan, incorporating information from her PCP.

Mia's care coordinator includes in her Care Plan her desired type, amount, and duration of 1915(i) services.

Mia's care coordinator submits her 1915(i) assessment and Care Plan to her Tailored Plan for service authorization.

